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INVITED COMMENTARY

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This prospective randomized trial supports the conclusions of most other similar studies indicating that the perioperative and midterm stroke and mortality rates for saphenous vein–patched and synthetic-patched carotid endarterectomy (CEA) are similar and low. It raises controversy concerning the management of severe recurrent stenosis, the value of ultrasound surveillance after CEA, and the importance of the statistically significantly higher rate of moderate (>50%) and severe (>70%) recurrent stenosis with Dacron-patched CEA compared with vein-patched CEA. The authors' indication for intervention in high-grade recurrent stenosis is development of ipsilateral symptoms. While their protocol allows for a superb natural history study of CEA, for which they are to be congratulated, it also negates the issue of the value of follow-up duplex scanning. On the basis of the observation that none of 11 patients in whom greater than 70% recurrent stenosis developed had symptoms, they recommend not performing serial ultrasound surveillance after CEA. Although it is well known that the incidence of stroke due to early and midterm recurrent stenosis is low, the risk of repeat intervention may be significantly lower. Eleven patients with recurrent stenosis is too small a number to hang one's hat on, particularly given the 95% confidence interval of 0% to 26% for observing no events in 11 samples (binomial distribution). The 7.1% rate of greater than 70% recurrent stenosis and the 12.4% rate of greater than 50% recurrent stenosis at 3 years reported in this study for Dacron-patched CEA are similar to what others have found. These 3-year rates only partially reflect what may occur later, when the major component of recurrent disease is atherosclerotic, not the earlier and more benign hyperplasia. Even though only 12% of the patients in this trial were operated on because of asymptomatic stenosis, it would be difficult for me not to offer serial ultrasound surveillance to patients operated on to treat asymptomatic stenosis and who received the Dacron patch. Further, if I had a high-grade carotid stenosis, I probably would not agree to receive a Dacron patch if I knew the moderate to severe recurrence rate was 7% to 12% in 3 years.

These somewhat biased comments aside, this trial emphasizes the need to clearly determine whether detection of asymptomatic recurrent stenosis after CEA (or after carotid angioplasty with stenting) and repeat intervention is of value in stroke prevention. Perhaps only certain subsets of patients may benefit from ultrasound surveillance.